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March 29, 2010

Victoria Alexander-Lane
Steele Memorial Medical Center
P.O. Box 700
Salmon, ID 83467

Provider #131305

Dear Ms. Alexander-Lane:

On **February 24, 2010**, a complaint survey was conducted at Steele Memorial Medical Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00004090**

**Allegation #1**: Patients who were anxious were not given sedatives before surgery.

Findings: An unannounced complaint survey was conducted on 2/24/10. Clinical records, facility policies, procedures, grievance logs were reviewed. Staff interviews were conducted.

Ten records of patients who had surgical procedures were reviewed for evidence of pre-operative anxiety and sedation. All records contained the same pre-operative orders.

One record documented the Certified Registered Nurse Anesthetist (CRNA) assessed the patient as being calm upon arrival to the operating room. The Anesthesia Record of the patient documented sedation was provided before the procedure, as per standard operating procedures.

In an interview with the Manager of Surgical Services, he stated the decision to provide pre-operative sedation is made by the CRNA who provides the care for the patient.

Determination of the appropriateness of sedation prior to surgical procedures is beyond the scope of this office. However, pre-surgical orders of surgical patients were consistent and it was not determined that patients were denied sedation prior to surgery.

It could not be determined the Critical Access Hospital (CAH) failed to provide sedation prior to surgical procedures, therefore the allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** Patients who were intubated by CRNAs experienced prolonged neck pain and/or injuries.

Findings: Clinical records and grievance logs were reviewed. Staff interviews were conducted. Ten records of patients who had surgical procedures in which endotracheal intubation were utilized, were reviewed. There was no documented evidence of complaints of neck trauma or post procedural pain.

One record reviewed contained a "Pre-Anesthesia Questionnaire," dated 4/10/08, but not timed, completed by the patient four days prior to surgery. It documented that, prior to the planned surgical procedure, the patient had neck and back pain with numbness of arms. The nursing assessment sheet, dated 4/14/08 at 8:43 P.M., completed by the RN post operatively, documented the patient's medical history was significant for arthritis.

In an interview with the Manager of Surgical Services and two RN supervisors, they stated they could not recall any patients that complained of neck pain post operatively.

It could not be determined that patients who were endotracheally intubated by CRNAs suffered neck pain or injuries, therefore the allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

**Allegation #3**: Patients were not notified that CRNAs were providing anesthesia.

Findings: Clinical records were reviewed and staff interviews were conducted. Ten records of patients who had surgical procedures with anesthesia were reviewed.

All records reviewed documented CRNAs met with patients and identified themselves prior to procedure. Patients then signed a "Consent for Anesthesia Services," which authorizied the identified CRNA to provide anesthesia services.

In an interview with the Manager of Surgical Services, he stated that patients have been informed of the utilization of CRNAs for anesthesia, as indicated on the "Consent for Anesthesia Services."

It could not be determined that patients were unaware of CRNAs providing anesthesia, therefore the complaint was unsubstantiated.

Conclusion: Unsubstantiated. Allegation did not occur.

**Allegation #4**: Staff were starting Intravenous (IV) infusions without wearing gloves.

Findings: Clinical records and grievance logs were reviewed. Staff interviews were conducted. Ten records of patients who had IVs were reviewed.

Four nurses were interviewed regarding the procedure for starting an IV. Each nurse was consistent in reciting procedural process, which included gloves.

Seventy-three grievances were reviewed. None identified improper technique with the starting of IVs or infections related to poor IV start techniques.

It could not be determined that staff were starting IVs without gloves, therefore the complaint is unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

**Allegation #5**: The CAH did not have a thorough grievance process.

Findings: Facility policies and grievance logs were reviewed. Staff interviews were conducted. Seventy-three grievances in a thirty-six month period were reviewed.

The facility had tracked grievances through a form titled, "QA Study Detail." One grievance reviewed showed the following chronological process:
a). Grievance filed on 9/26/08
b). 9/28/08-conference with CEO.
c). 10/1/08-patient visit to talk with Grievance Officer.
d). 10/2/08-Grievance Officer conferred with involved parties as well as CEO for judgment.
e). 10/7/08-final letter written and mailed.
f). Total time of process from initiation to letter of resolution was eleven days.

There was a letter sent the by the family, responding to the written notification of resolution by the Grievance Officer. The letter by the family requested further review of the grievance.

The facility responded to the patient with a final letter 3 months later; after the clinical records had been sent out for external review and a decision had been made.

Review of the Policy "Patient Grievance Process," dated 1/05, documented in detail how a patient complaint would be followed. Review of sixty-eight complaint records indicated that the process was followed as the policy directed. Five complaint records reviewed documented a verbal response was provided rather than a written response and there was no documentation the complainants requested a written response and therefore were not dissatisfied with the verbal response provided.

It could not be determined that the facility did not have a thorough grievance process, therefore the complaint was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw